A lack of insight? — Understanding some ways inadvertent iatrogenic harm can occur (part 1)

Author's note: What follows is adapted, with some additions and amendments, from the working script for a presentation I gave at the November, 2024 Critical Voices Network Ireland conference. The theme of the conference was on *responding to iatrogenic harm in mental health.*

The approach might be considered sketchy and exploratory in nature. For readability, I have split it into two parts, rather than having one single lengthy blog post.

About seven years ago, I was attending a launch event in Huddersfield for a partnership of organisations working locally with people with 'multiple complex needs' — meaning issues around homelessness, addiction, offending and mental health.

Anyway, a few minutes before the start, I sat down at the least occupied table, where there were two middle-aged women. They told me they worked at a hostel nearby. I was asking about how they found their work, and the main thing I remember about the conversation is their remarking about the issue of mental health in the field:

"*Once you've got that, you don't get better.*"

I didn't say anything. I couldn't. It wasn't, after all, the most encouraging thing for me to hear. Not least at an event for services aimed at supporting recovery. But, in a way, they were making a valid point. Because, all too often that seems to be the trajectory for mental health service users — they don't get better.

And attempting to understand some of the dynamics that can mean people who receive care for their mental health don't improve, or even fall into a deteriorating spiral, is what I try to scratch the surface of here.

I guess it's tempting for people with lived experience, who feel they've gained a bit of understanding, to want to say the answers they've found work for them are going to be helpful in general. But it's potentially mistaken to extrapolate too much from one case, even if it's the one you know best. However, it's the assumptions, often tacit, that are made about someone presenting with mental health symptoms, and the danger of those assumptions that I want to address in this presentation.

Iatrogenic harm is a complex, knotty subject with different aspects, and different strands to its context and background. So, there are a lot of relevant topics, that I can't really cover here. For instance, I'm not here, discussing here issues like restraint, coercion, or the bullying and abuse that can happen.

And I won't talk here about more obvious examples of poor practice or negligence. Sometimes problems are triggered due to a lack of diligence over medical records, or the interpretation of guidance. For instance, a person is prescribed a drug they clearly shouldn't have been, when:

- a contra-indicated drug is prescribed
- or drugs that have already have been shown to be 'non-therapeutic' for the patient are re-prescribed.

What I am going to look at here is iatrogenesis that may happen when the treatment is within, more or less, the 'standard of care' or 'best practice' as given in guidelines from the relevant professional and regulatory bodies.

A major part of the context for this is, of course, the practices of 'Big Pharma'. Ultimately, I don't think you can address this aspect of iatrogenic harm properly, without wider changes in the regulation of the pharma sector and establishing checks against the commercialisation of healthcare research.

I won’t focus much on that here. But, as I say, the issue is kind of unavoidable in exploring this theme.

That’s an issue on the supply-side *as it were,* but what about the demand for mental health services?Well, that demand arises from society and will obviously tend to reflect social problems.

Over the last decade, this tongue-in-cheek, spoof diagnosis has entered public debate. With a recognition from overwhelmed GPs and other practitioners that they can’t fix issues — arising from deprivation or harrowing personal circumstances — just by doling out a prescription for an antidepressant. And that doing so often isn’t inappropriate.

The idea carries with it the implication that, in some sense, society has been “overmedicalising” the problems of living that its members can face.

How did that ‘overmedicalisation’ come about?

There are many factors that have driven that overmedicalisation, but one that several commentators have pointed to is the use of symptom based rating scales for mental health issues like; depression, anxiety or ADHD. Which will tend to mark people that are reasonably healthy, but maybe struggling with challenges in their lives, as being over the threshold for some diagnosable mental health condition. And this then results in more prescriptions of

‘antidepressants’ or other psychiatric drugs, than is really warranted.

Assessment tool for ‘Generalised Anxiety Disorder’

The idea here being that:

“symptom — based logics generate inflated prevalence estimates…

One theme of this presentation is that this inflation of a diagnosis’ prevalence (sometimes called ‘bycatch’) is due to the nature of the causes of such ‘symptoms’ and also to the nature of our assumptions about those diagnoses. Basically, that:

- **symptoms have multiple potential causes**
- whereas**, a diagnosis usually attributes them to a single condition.**

If you put those features together you can, I hope, see how a potential inflation of a diagnosis’ commonplaceness can occur.

Moreover, in society as it actually is:

… these* [prevalence] *estimates are created and perpetuated because a number of particular groups have distinct interests in demonstrating the presumed pervasiveness of mental illness.” (George Graham)

Indeed, the commonly used PHQ9 and GAD7 questionnaires were formulated by psychiatric experts, including Robert Spitzer, contracting for Pfizer.

Where does one typically fill in a GAD7 or PHQ9 questionnaire?

Let’s take a hypothetical case history — one not entirely unlike my own. It might start with a visit to the GP about some mild ‘mental health’ issue. Say that, for whatever reason, you present to services with milder anxiety or depression. And typically, with a 10 or 15 minute consultation you are prescribed an SSRI - a newer type of drug from those used as ‘antidepressants’.

In the 90’s we were told that they had the answer to all the little unhappinesses in life in the form of prozac and its analogues.

Taking an SSRI may well activate you, make you feel more motivated, give you some “get up and go” and block out any worries you might have been having. But, this comes with some concerning, even alarming, possible effects. Links are seen with symptoms like: impulsivity, aggression, suicidality, disinhibition volatility, emotional blunting or indifference to others, loss of sensitivity.

Some adverse events from SSRIs in adolescents Although this data is from a adolescent cohort, such issues are manifested across all age brackets.

As has become increasingly apparent since the nineties, once prescribed these drugs you are at greater risk of developing manic and/or psychotic symptoms.

Another prescription that can trigger mania or impulsivity, appears to be when youngsters are given drugs like Ritalin or Adderall for ADHD. These are amphetamines with dopaminergic effects.

Individuals are 13 times more likely to develop psychosis after taking

Adderall, according to this recent study. So, if the baseline chance for a youngster of developing psychosis within the next few years was, say 1%, then after starting on a high dose of Adderall, they then have about a 1 in 8 chance of developing a psychosis. Which doesn't seem that rare.

"Unmasking"

If you do go on to suffer some such episode, then medics may, subsequently tell you that the SSRI has 'unmasked' your "latent bipolar disorder" or perhaps 'latent schizoaffective disorder'

Implying that you've really always had 'latent bipolar.' You may even be told that you were misdiagnosed beforehand, but after this 'unmasking', you've now got your true diagnosis. *It's almost as if those drugs have done you a favour in precipitating a manic episode. Because now you've got your true diagnosis!*

But, could they not more simply have said:

"You appear to be more sensitive than average to the SSRI's (or whathaveyou) *activating effects."*

In any case, you would've gone from presenting with a milder type of mental health complaint, to receiving a more severe diagnosis, and consequently, likely to a more intense level of evaluation from services. And probably, you now will be prescribed a different drug class, such as a 'mood stabilizer'.

Let's say, in a case where someone on a SSRI for depression develops such an episode, they're assessed as having '*manic symptoms with some element of psychotic disturbance'*. Meaning, quite likely, a diagnosis of 'schizoaffective disorder'.

What that diagnosis is claiming to refer to is unclear. *Perhaps that the person has a bit of schizophrenia and a bit of bipolar. But if this is allowed, then the notion that a clear distinction between signs of 'schizophrenia' and of signs of 'bipolar' can be made, is clearly untenable.*

In any case, the practical upshot of receiving a diagnosis of 'schizoaffective disorder' will be being prescribed two or three different drugs in their ongoing treatment; 'mood-stabilizers' and 'antipsychotics' and perhaps an 'antidepressant' also.

US data for 2008- Nearly 40% with the diagnosis are prescribed three classes of drug

As J.Moncrieff reminds us, those are essentially marketing names applied by drug companies to their products. In the case of ‘antipsychotics’ the drugs are also called ‘neuroleptics’ or ‘major tranquilizers’. While ‘mood stabilizers’ are also known as ‘anti-epileptics’ or ‘anti-convulsants’. Like neuroleptics, mood stabilizers act as suppressants of the central nervous system, and come with their own set of morbidities.

Anyway, that’s three sets of potentially adverse drug effects for those on such a maintenance treatment programme.

Ongoing effects of neuroleptics

Taking the longer term effects of just one of those drug classes here: Over time you may find, as I did, that you can sleep and eat more than usual; have little interest in getting out and about; feel blank, not having much to say, with what is called ‘impoverished speech’- slurred speech or other impediment, perhaps due to motor retardation effects on the fine muscles controlling the mouth.

Effects such as these will be taken by many, including quite possibly family members, not as the effect of major tranquillizers, but as confirming your diagnosed illness, and that you “have something wrong with you”. Indeed, from a clinical perspective the outward effects of the neuroleptic are likely to be taken as “negative symptoms” of a ‘schizophreniform disorder.’

So, it often happens that the ‘side-effects’ of central nervous system suppressant drugs like ‘antipsychotics’ are interpreted as signs confirming the reality of the diagnosis, that they are supposedly treating.

Are there any upsides to neuroleptic use? *Well, perhaps for prison management.*

One antipsychotic, ‘seroquel’ can even become a ‘drug of choice’, with some prisoners seeking it, for a way to sleep through in a stressful environment.

(My own experience of taking quetiapine as maintenance treatment was that I could easily sleep up to 12 hours and then still feel groggy after getting up.)

However, the use of these drugs in general populations has been warned against.

Dr Peter Breggin has made the case that the end result of ongoing intake of such compounds will be what he has termed ‘chronic brain impairment’. That’s likely to result in some degree of social or occupational disability.

Also, and I’m afraid to have to say it, these drugs are known to cause cerebral atrophy.

Frustratingly, to this day, some ‘schizophrenia experts’ treat this consequence as being some pathology of ‘schizophrenia’. Which is another example of drug effects being misinterpreted as signs of some putative condition they are said to be treating.

Life as an outpatient

Thinking at an everyday level, about the challenges service users face, given all these health effects and impairments, I hope people can start to see that society is putting conflicting demands on service users.

It’s natural that families will expect a young person to *“make something of their self”.* And society will frown on the economically inactive. Whilst in recent years, the government in Britain expects mental health services to

meet targets around employability; referring their patients onto work coaching programmes, volunteering, and so on.

But, how can service users be expected to make appointments, let alone search for a job and manage their household, if they are sleeping 12 hours a day?

Out-patients effectively face a dilemma:

- **Comply with the maintenance treatment regime:** Accepting the limitations and potential longer-term health complications this places on you. *(Some who do this, I must admit, have relative stability in their lives and may go on to enjoy the benefits from full-time employment. But, my sense is this group tend to have a strong support networks around them.)*
- **Risk 'non-compliance':** Which comes with some potential complications that aren't easy to manage.

As the work of Mark Horowitz among others has shown, the cumulative effect of extended treatment with 'antipsychotics' will be for the brain to develop some propensity to *dopaminergic hypersensitivity (or 'supersensitivity').* This is due to the brain's compensatory adaptation to the effects of dopamine receptor blockade; more dopamine receptors grow. Resulting in an increased density of them in parts of the brain.

Thus, should you find the effects of the drugs unpleasant, or obstructive to having some quality of life, and not knowing all that about acquired ‘dopaminergic supersensitivity’ *(I mean, why would you?)* decide to take yourself off. *What’s likely to happen then?*

You are likely to experience the consequences of an effective surge in a dopaminergic signalling, and suffer what’s called ‘rebound psychosis’ amidst other, more somatic withdrawal symptoms.

These effects usually haven’t been understood as drug withdrawal effects. More likely, they’re assessed as a relapse of the condition for which you were prescribed antipsychotics. Or perhaps, those withdrawal effects will be attributed to some new psychiatric condition. That you are now said to have on top of your pre-existing diagnosis.

But, even if you don’t discontinue, that compensatory proliferation of dopamine receptors produces a potential sensitization - still there *under the*

surface — which probably has heightened your susceptibility to stress and/or other fluctuations of the nervous system, including for example, the effects of certain drugs (illicit or otherwise) that act on the dopamine or serotonin systems.

Any ‘dabbling’ with drugs will then be more likely to result in a persistent episode. Such events are again likely to treated by services as a ‘relapse’ or appearance of some other diagnosable feature of a severe mental illness.

But, *let’s say you are well behaved* - staying on your neuroleptics and avoiding consumption of other drugs.

Seeing you affected by features like; lack of motivation, memory loss, impaired speech, facial masking *etc,* your clinical team agree to try switching you to a different “antipsychotic”.

Among the options, the go-to choice for younger men with ‘schizophreniform’ diagnoses has been aripiprazole (Abilify). Promoted as having low side effect profile. By 2013–2014 it was leading the market share in the US.

Following the 2nd iteration of the dopamine hypothesis: Abilify was promoted as down-regulating circuits associated with positive symptoms, while up-regulating circuits associated with negative symptoms. Things didn’t turn out so neatly.

The switching procedure would likely be overseen by services in a relatively short time-frame, say 2 weeks, at most. Quickly phasing out one and phasing in the Abilify.

Unlike most other antipsychotics, which are dopamine receptor antagonists, it is said to be a ‘partial dopamine agonist’. Described as “regulating” dopamine rather than blocking it, it has some ‘affinity’ with the receptors, activating them to some degree.

Comparative illustration only

But, in switching someone who's acquired dopaminergic supersensitivity from their exposure to a dopamine receptor antagonist, to a partial agonist fairly abruptly, problems are likely, including: **akathisia** (intense restlessness), compulsions, agitation etc. These effects due (in theory as I understand it) to dopaminergic overstimulation of the mesocortical pathway.

(Source)

I would hypothesize that a large proportion of the people prescribed Abilify would have been *pre-sensitized* by taking standard D_2 receptor blockading drugs beforehand. This, quite potentially exacerbating the drug's adverse effect profile.

If you were unstable or in a crisis in life. These effects, including sleeplessness

and tremors are unlikely to help and could even result in suicidality.

In the US, the company BMS settled out of court with patients who sued, saying the drug can cause “uncontrollable compulsive behaviour”. These adverse effects (like akathisia) were glossed over by the medical experts who wrote pieces for the product’s marketing.

For staff in mental health services, it would though be quite easy for practitioners to mistake akathisia symptoms as being due to, say, an ‘anxiety disorder’ (or perhaps stress from the patient’s paranoia). Especially, if those staff weren’t properly aware of potential adverse effects from starting Abilify.

Could you tell the difference?

Signs and symptoms of ‘generalised anxiety disorder and ‘akathisia’

As I hope you can see, there is some degree of overlap in the symptoms rated in the these two diagnostic tools. This looks to me, to be a potential way adverse drug (or drug withdrawal) effects can be misdiagnosed.

Self-medication — kicking the can down the road.

Unpleasant prescription drug effects like akathisia can drive ‘self-medication’. Even at the milder end of akathisia — perhaps resulting from changes brought about by past exposure to psychiatric drugs - you may seek relief of symptoms through alcohol consumption, or cannabis, or benzos, and so on.

As the psychiatrist David Healy remarked in a recent of his presentations, alcohol can be an effective relief for akathisia symptoms. To me, this no doubt explains why a lot of people with complex issues will turn to it.

At one stage, the simplest way for me to ‘feel human’ was having two or three pints of beer. I might’ve then seemed more at ease and relatable, rather than being a nervous wreck. But obviously, that only worked for a couple of hours or so. And then…

But such responses are likely to mean people stagnating in their current pattern of living, rather than progressing to some meaningful and sustained recovery. Whilst the potential for some ‘relapse’ event will tend to loom ever larger.

Psychiatric condition or iatrogenic symptoms?

I think, one can argue (as I take David Healy as suggesting) that in cases where people continue ‘relapsing’ or receive changing diagnoses; is that such abrubt changes in clinical presentation are effectively, manifestations of a (poly) ‘drug-evoked nervous system dysregulation’. In which, further drug interventions exacerbate the enduring consequences of past ones. And not sudden relapses of some underlying, or people acquiring discrete new illnesses.